Can you add value to QOF - and improve your QOF points - the role of DSP

Decision Support & Performance

Christine A'Court, Sue Trinder, Iona Rees, Rosemary Smith, Mohammed Ali, Chris Morris

Reconfiguration 2005

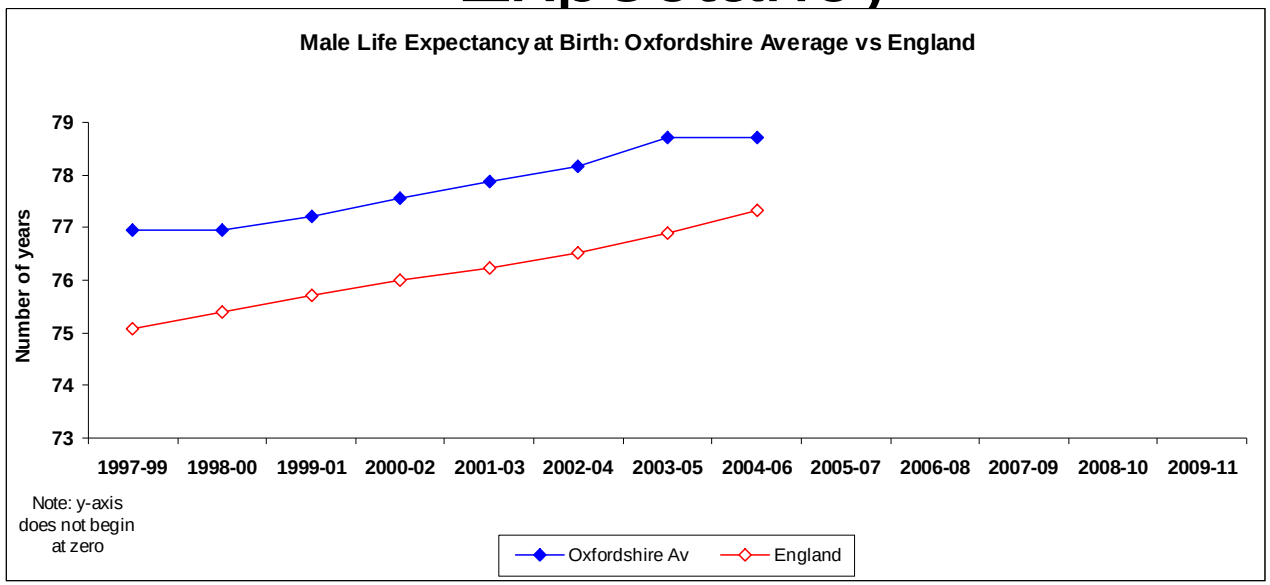
- ‘Decision Support & Performance’ formed by bringing together
  - MAAG
  - Public health Information team
  - Secondary Care Information team
  - Community Information teams (for D/Ns, HVs and allied health professionals)
- Working with PCT commissioners, contract team, & providers in the community eg primary care
- New perspectives and wider range of activities!

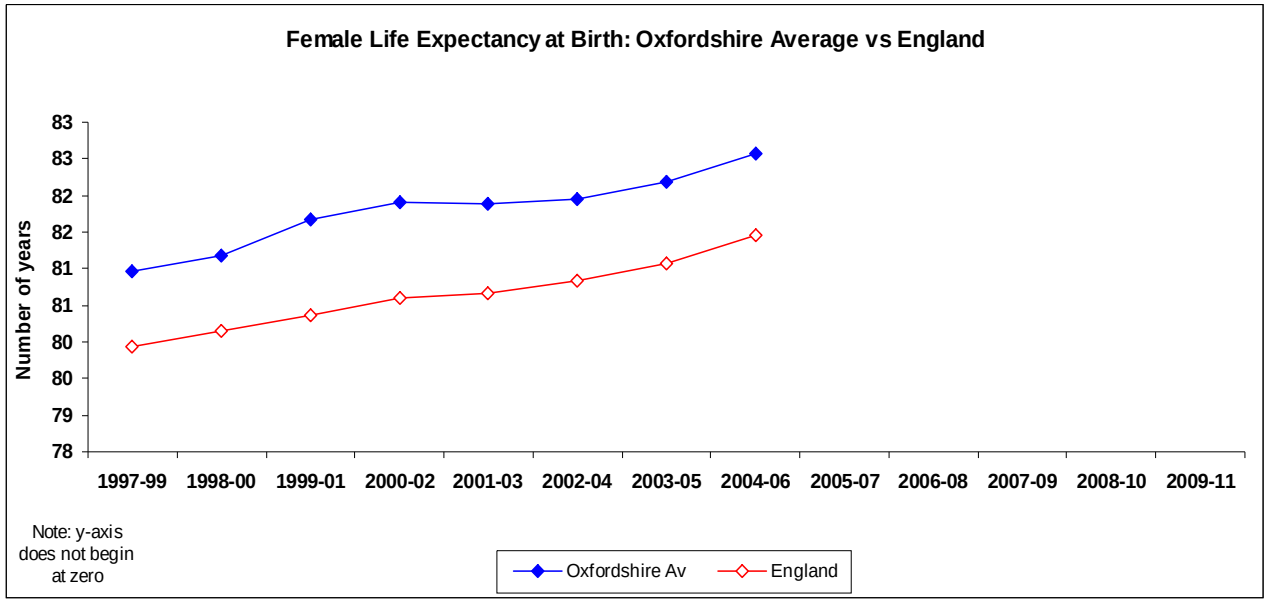
UK PCT Spending by category
(NB Oxon primary care highest budget)

Programme Budgeting – ranked position (spend per 100k population		Highest (Top 10%)	High (10 – 25%)	Average (25 – 75%)	Low (75 – 90%)	Lowest (Bottom 10%)	Value percentile
1	Infectious Diseases					7 (8)	98
2	Cancers and Tumours			4 (4)			52
3	Disorders of Blood			5 (5)			62
4	Endocrine, Nutritional and Metabolic			1 (1)			44
5	Mental Health Disorders			5 (5)			74
6	Problems of Learning Disability			3 (3)			46
7	Neurological		2 (2)				45
8	Problems of Vision			4 (4)			50
9	Problems of Hearing			6 (6)			74
10	Problems of Circulation			5 (5)			47
11	Problems of the Respiratory System			6 (6)			58
12	Dental Problems				8 (8)		52
13	Problems of Gastro Intestinal System			5 (5)			55
14	Problems of the Skin			5 (5)			70
15	Problems of Musculo-skeletal System	1 (1)					23
16	Problems due to Trauma and Injuries				9 (9)		69
17	Problems of Genito-urinary System		2 (2)				58
18	Maternity and Reproductive Health				6 (6)		79
19	Conditions of Neonates	1 (1)					35
20	Adverse effects and poisoning	2 (2)					22
21	Healthy Individuals			6 (6)			83
22	Social Care Needs			4 (4)			95
23	Other			3 (3)			77
23a	General Medical Services/ Personal Medical Services	1 (1)					29
Total	Total		2 (2)				65

1a

Trends in health improvement – Life Expectancy





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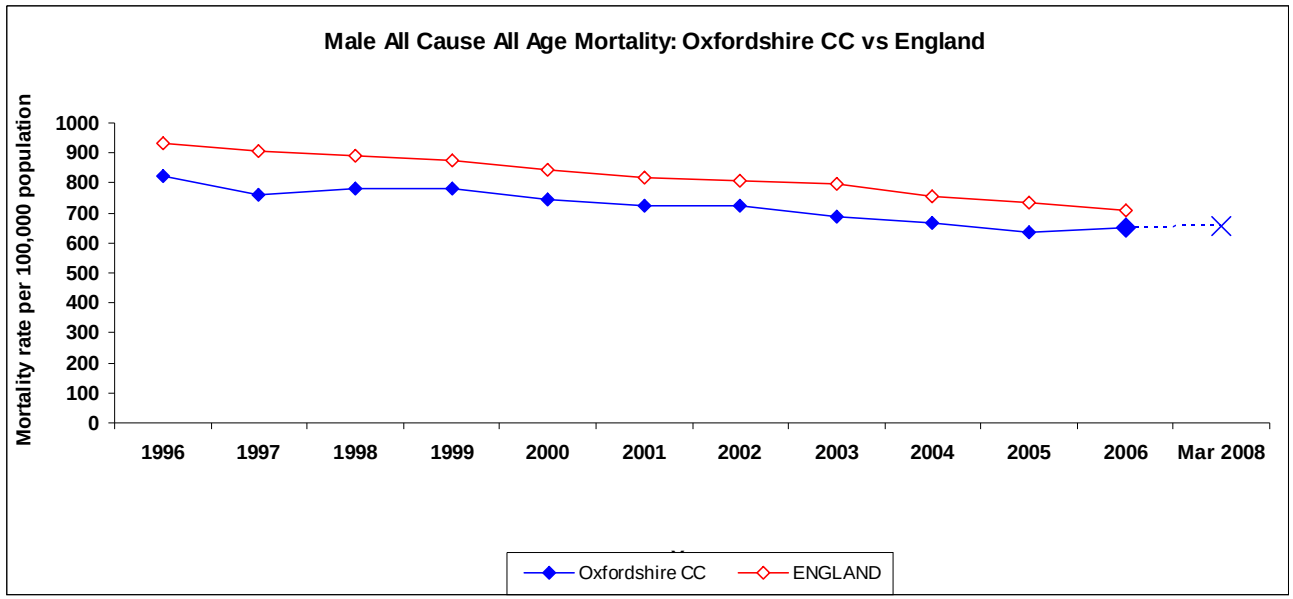
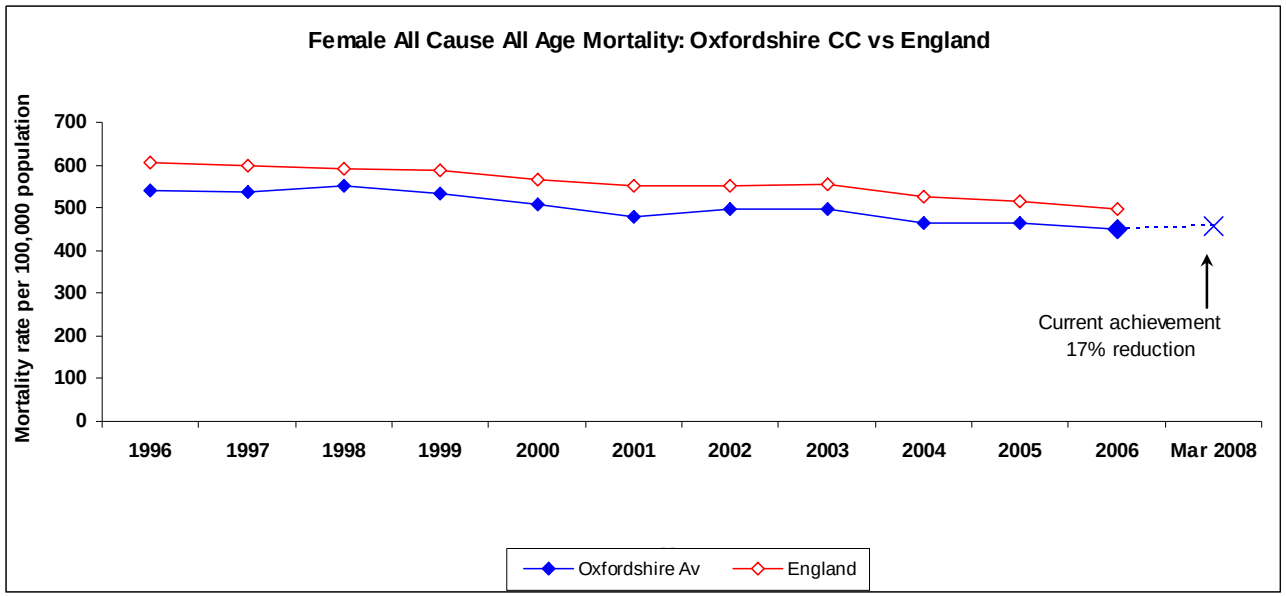
Trends in health improvement – Mortality





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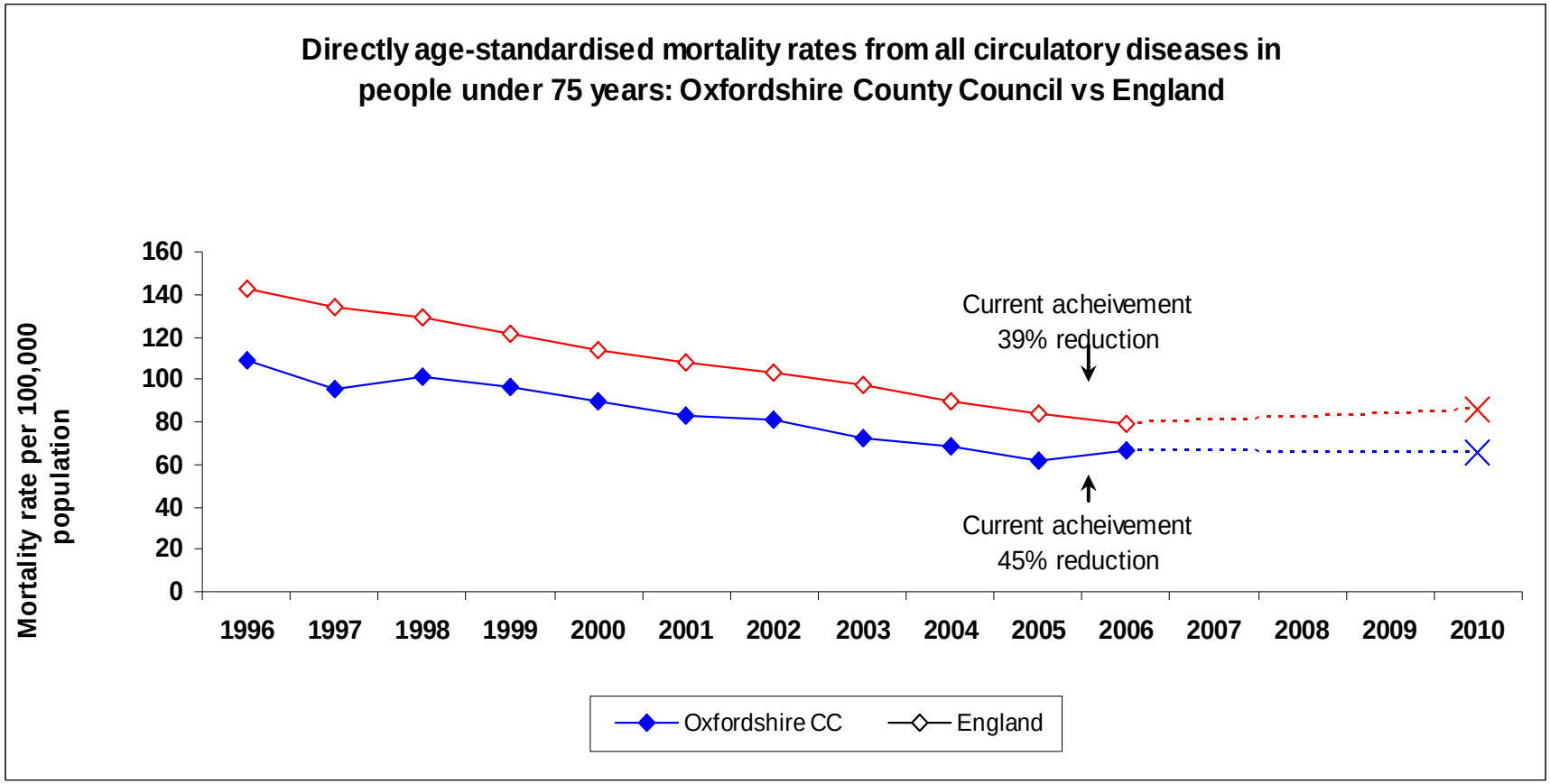
Trends in health improvement - Circulatory Diseases



National performance targets partly met in 2007/08

- Ambulance: Cat A 19 minutes
- Ambulance: Cat B 19 minutes
- Delayed transfers of care
- A & E: 4 hour wait
- GP recording of BMI

National performance targets not met in 2007/08

- Four week smoking quitters
- Teenage conception rates
- Cancer mortality rate
- Cholesterol levels
- Access to reproductive health services
- Access to a GP and Primary Care Practitioner
- % bookings via Choose and Book
- Thrombolysis: 60 minute wait
- CPA 7-day follow up

QOF

Disease Registers: Prevalences

- Sources of raw prevalences
  - QMAS
  - PCT comparators from https:/nww.pctcomparators.nhs.uk
    - **eg Hypertension Prevalence**
    - Bottom 5th percentile for SHA (9 PCTs)
    - 2nd lowest in ‘prospering southern England’
    - Bottom decile nationally (152 PCTs)

- Source of age-sex standardised prevalences
  - QUEST now enables DSP to convert raw prevalences to age-sex standardised prevalences, and publish inter-practice comparisons

Raw prevalence from QMAS: on https:/nww.pctcomparators.nhs.uk

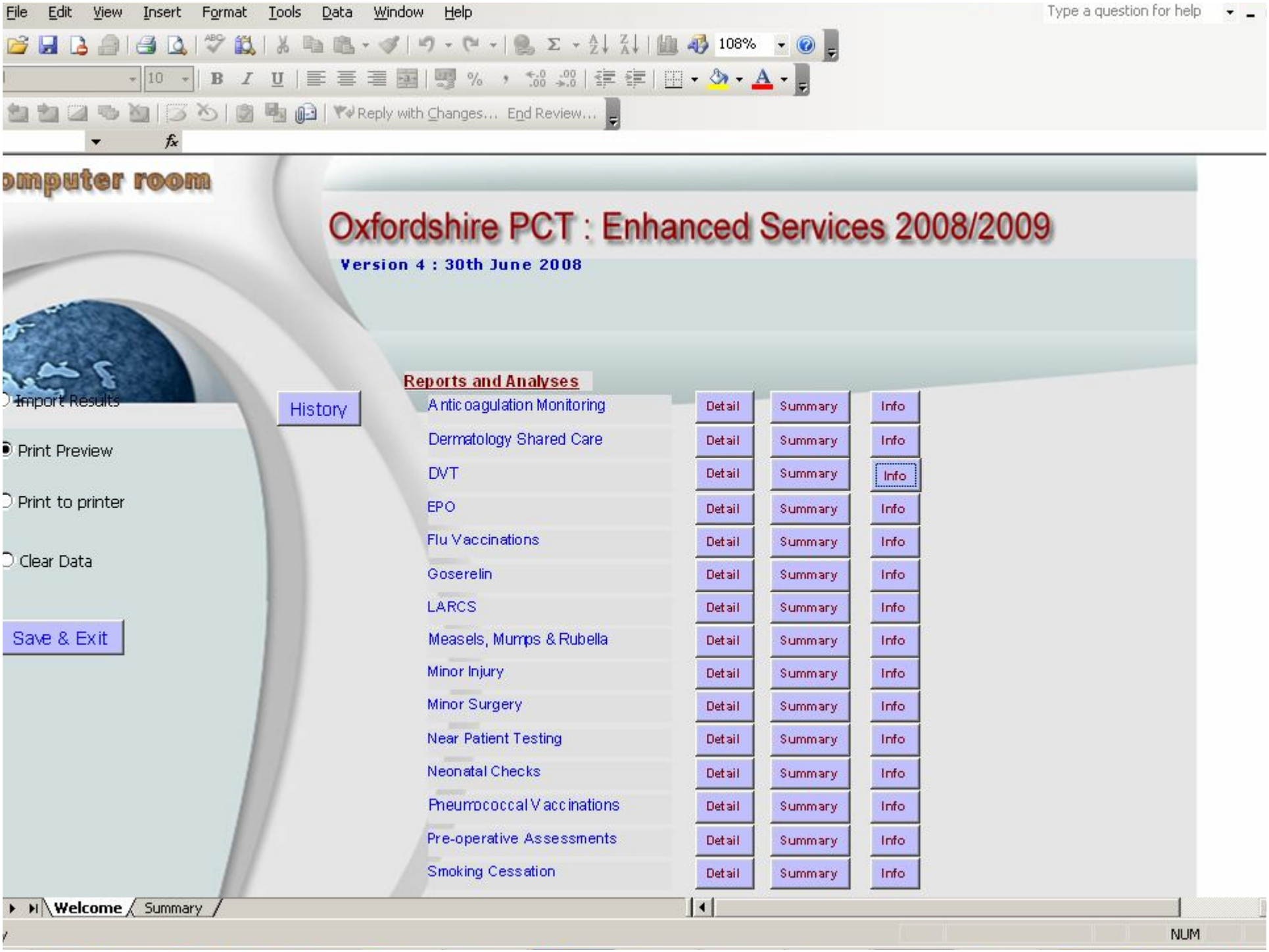
Quintile	Lowest 20 %	21-40%	41-60%	61-80%	Highest 20 %
Asthma					
Cancer					
CHD					
COPD					
Diabetes					
Hypertension					
Stroke					
Mental Health					
Dementia					

QUEST

- Out-sourcing of most time-consuming of MAAG work!
- ‘The Computer Room’ in Nottingham
- License paid by PCT: £300 per practice
- Web-based MIQUEST tools
- Enhanced Services data collection
- Now include Vascular Disease Audits (CHD, Stroke/TIA, PVD, HT -all based around MAAG audits)
- Also ‘High risk CVD’ tool (for an additional licence fee)

Use of QUEST for Enhanced Services

DESs & LESs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Version 4 : 30th June 2008
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Dermatology Shared Care
DVT
EPO
Flu Vaccinations
Goserelin
LARCS
Measels, Mumps & Rubella
Minor Injury
Minor Surgery
Near Patient Testing
Neonatal Checks
Pneumococcal Vaccinations
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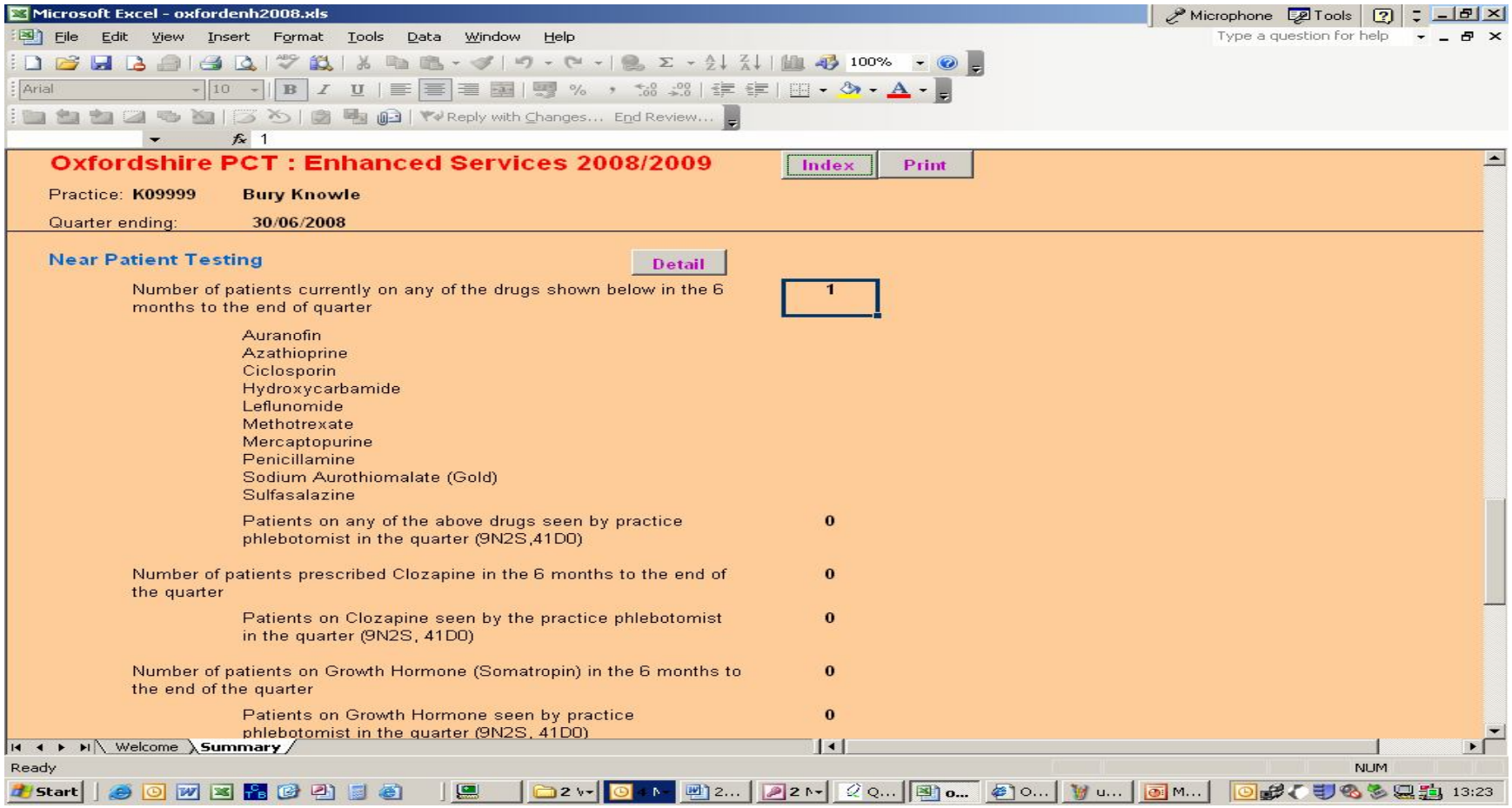
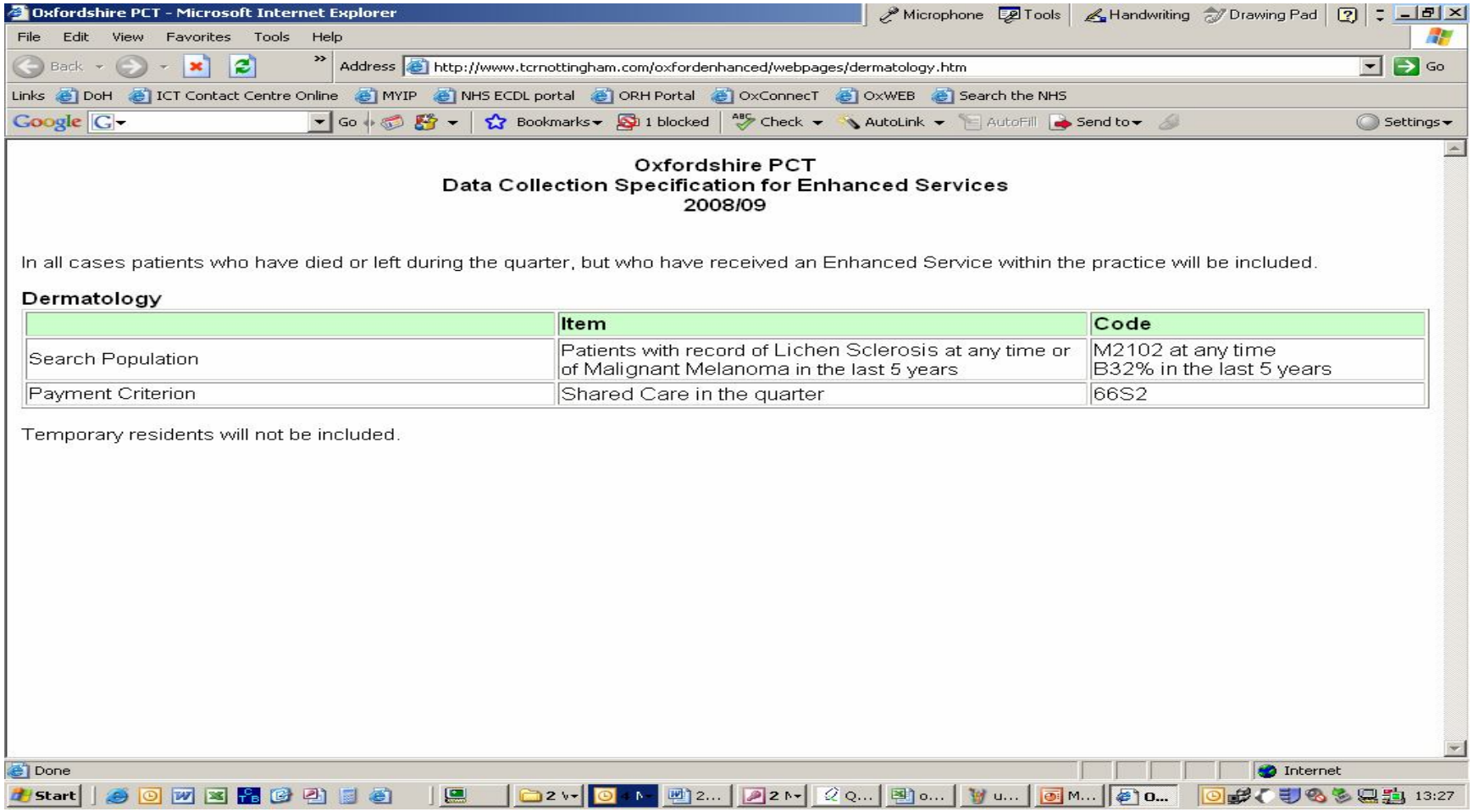


Clozapine 2008-09: data now collected is clozapine prescribed OR monitored (4Q19). For governance reasons you *should* enter clozapine on med screen as ‘issued outside’

Shared Care


Oxfordshire PCT - Microsoft Internet Explorer
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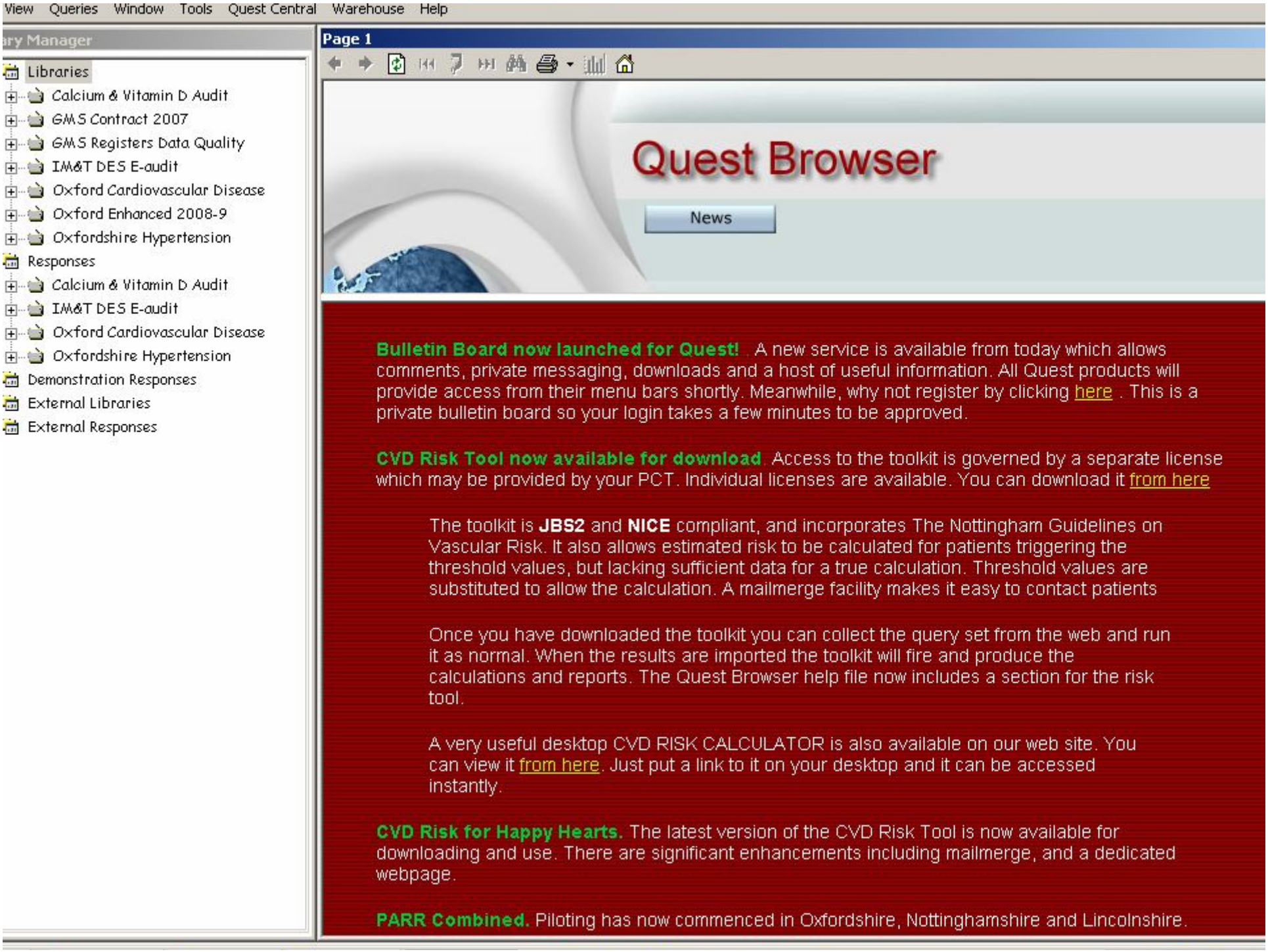
Address http://www.tcrnottingham.com/oxfordenhanced/webpages/dermatology.htm
Links DoH ICT Contact Centre Online MYIP NHS ECDL portal ORH Portal OxConnecT OxWEB Search the NHS
Oxfordshire PCT
Data Collection Specification for Enhanced Services
2008/09
In all cases patients who have died or left during the quarter, but who have received an Enhanced Service within the practice will be included.
Dermatology
Item
Code
Search Population
Patients with record of Lichen Sclerosis at any time or of Malignant Melanoma in the last 5 years
M2102 at any time
B32% in the last 5 years
Payment Criterion
Shared Care in the quarter
66S2
Temporary residents will not be included.
Done
Internet
Start
13:27

QUEST for CVD and HT audits

Closely modelled on MAAG cross-county comparative audits.
Complementing not duplicating QOF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Oxford Enhanced 2008-9
Oxfordshire Hypertension
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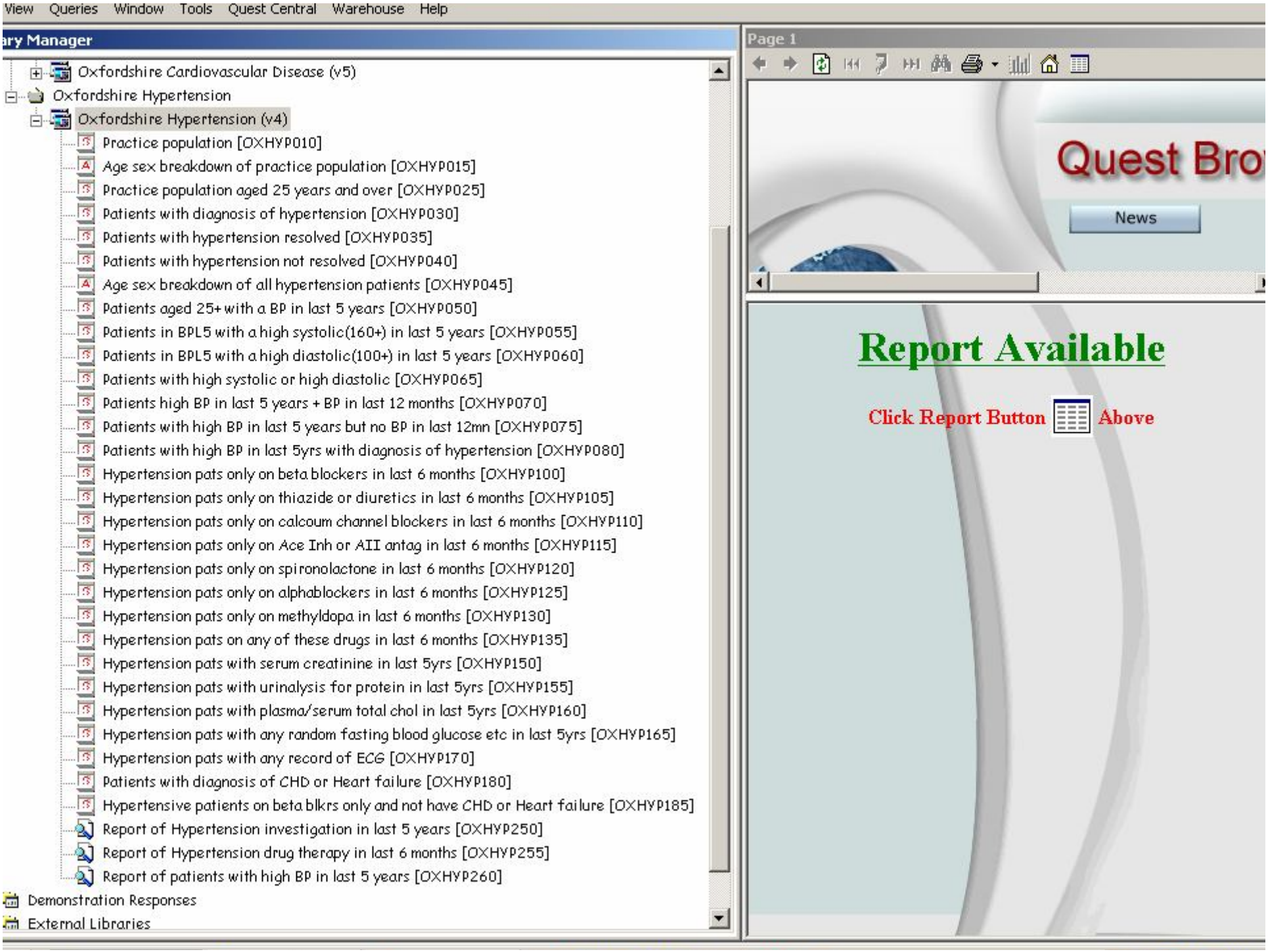
Demonstration Responses
External Libraries
External Responses
Page 1
Quest Browser
News
Bulletin Board now launched for Quest! . A new service is available from today which allows comments, private messaging, downloads and a host of useful information. All Quest products will provide access from their menu bars shortly. Meanwhile, why not register by clicking here . This is a private bulletin board so your login takes a few minutes to be approved.
CVD Risk Tool now available for download . Access to the toolkit is governed by a separate license which may be provided by your PCT. Individual licenses are available. You can download it from here
The toolkit is JBS2 and NICE compliant, and incorporates The Nottingham Guidelines on Vascular Risk. It also allows estimated risk to be calculated for patients triggering the threshold values, but lacking sufficient data for a true calculation. Threshold values are substituted to allow the calculation. A mailmerge facility makes it easy to contact patients
Once you have downloaded the toolkit you can collect the query set from the web and run it as normal. When the results are imported the toolkit will fire and produce the calculations and reports. The Quest Browser help file now includes a section for the risk tool.
A very useful desktop CVD RISK CALCULATOR is also available on our web site. You can view it from here. Just put a link to it on your desktop and it can be accessed instantly.
CVD Risk for Happy Hearts. The latest version of the CVD Risk Tool is now available for downloading and use. There are significant enhancements including mailmerge, and a dedicated webpage.
PARR Combined. Piloting has now commenced in Oxfordshire, Nottinghamshire and Lincolnshire.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Oxfordshire Cardiovascular Disease (v5)
Oxfordshire Hypertension
Oxfordshire Hypertension (v4)
Practice population [OXHYP010]
Age sex breakdown of practice population [OXHYP015]
Practice population aged 25 years and over [OXHYP025]
Patients with diagnosis of hypertension [OXHYP030]
Patients with hypertension resolved [OXHYP035]
Patients with hypertension not resolved [OXHYP040]
Age sex breakdown of all hypertension patients [OXHYP045]
Patients aged 25+ with a BP in last 5 years [OXHYP050]
Patients in BPL5 with a high systolic(160+) in last 5 years [OXHYP055]
Patients in BPL5 with a high diastolic(100+) in last 5 years [OXHYP060]
Patients with high systolic or high diastolic [OXHYP065]
Patients high BP in last 5 years + BP in last 12 months [OXHYP070]
Patients with high BP in last 5 years but no BP in last 12mn [OXHYP075]
Patients with high BP in last 5yrs with diagnosis of hypertension [OXHYP080]
Hypertension pats only on beta blockers in last 6 months [OXHYP100]
Hypertension pats only on thiazide or diuretics in last 6 months [OXHYP105]
Hypertension pats only on calcoum channel blockers in last 6 months [OXHYP110]
Hypertension pats only on Ace Inh or AII antag in last 6 months [OXHYP115]
Hypertension pats only on spironolactone in last 6 months [OXHYP120]
Hypertension pats only on alphablockers in last 6 months [OXHYP125]
Hypertension pats only on methyldopa in last 6 months [OXHYP130]
Hypertension pats on any of these drugs in last 6 months [OXHYP135]
Hypertension pats with serum creatinine in last 5yrs [OXHYP150]
Hypertension pats with urinalysis for protein in last 5yrs [OXHYP155]
Hypertension pats with plasma/serum total chol in last 5yrs [OXHYP160]
Hypertension pats with any random fasting blood glucose etc in last 5yrs [OXHYP165]
Hypertension pats with any record of ECG [OXHYP170]
Patients with diagnosis of CHD or Heart failure [OXHYP180]
Hypertensive patients on beta blkrs only and not have CHD or Heart failure [OXHYP185]
Report of Hypertension investigation in last 5 years [OXHYP250]
Report of Hypertension drug therapy in last 6 months [OXHYP255]
Report of patients with high BP in last 5 years [OXHYP260]
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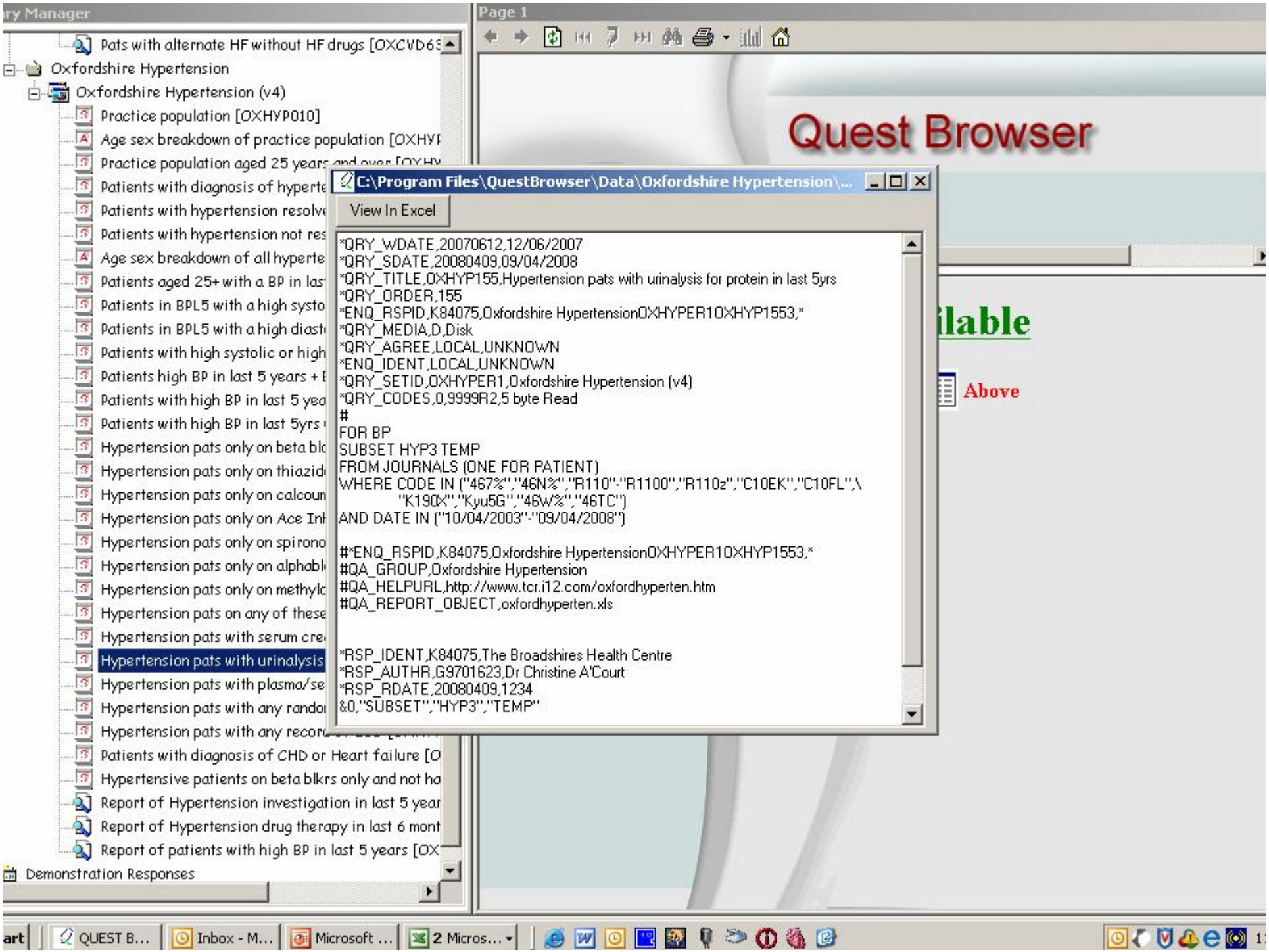
ry Manager
Pats with alternate HF without HF drugs [OXCVD63
Oxfordshire Hypertension
Oxfordshire Hypertension (v4)
Practice population [OXHYP010]
Age sex breakdown of practice population [OXHYP
Practice population aged 25 years and over [OXHY
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Hypertension pats with plasma/se
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Hypertension Audit

Print | Welcome | Report | Graphs

K84075 The Broadshires Health Centre
Period: 09/04/2008

Populations	Nos	%
1. Practice population	8482	
2. Patients in practice population aged 25 and over	5409	63.8
3. Patients with a diagnosis of Hypertension	709	8.4

Section One: Assessing the accuracy of the Hypertension register

1.1 Patients aged 25 and over, with any record of high BP (>/= 160mmHg systolic or >/= 100mmHg diastolic) in the last 5 years	750	13.9
1.2 who have not had a BP recorded in the last 12 months	111	14.8
1.3 who are on the nGMS Hypertension register	465	62.0

Section Two: Thresholds for drug treatment, and choice of drug treatment in Hypertension

1.1 Anti-hypertensive treatment during previous 6 months in patients with a diagnosis of Hypertension	653	92.1
2.1 Total number of patients with Hypertension on monotherapy in the last 6 months	284	40.1
2.2 Thiazides or diuretics	34	12.0
2.3 Calcium channel blockers	36	12.7
2.4 Ace inhibitors or AII antagonists	181	63.7
2.5 Spironolactone	2	0.7
2.6 Alphablockers	1	0.4
2.7 Methyldopa	0	0.0
2.8 Beta blockers	30	10.6
2.9 Beta blockers who do not have CHD or Heart Failure	24	80.0

Section Three: Investigations required as part of assessment of Hypertension and routine follow-up

1.1	Patients with a diagnosis of Hypertension and a record of Serum creatinine in the past 5 years	**676**	95.3
1.2	Patients with a diagnosis of Hypertension and a record of urinalysis for protein in the past 5 years	**314**	44.3
1.3	Patients with a diagnosis of Hypertension and a record of Serum total cholesterol in the past 5 years	**658**	92.8
1.4	Patients with a diagnosis of Hypertension and a record of Fasting blood glucose or HbA1c in the past 5 years	**660**	93.1
1.5	Patients with a diagnosis of Hypertension and a record of ECG at any time	**435**	61.4

DoubleClick on blue numbers to list the respective patients on the appropriate sheet.

rdiovascular Disease Audit

Print | Welcome | Audit | Graphs

75 The Broadshires Health Centre

od: 09/04/2008

Double-click table name for graph

Sex Patients Distribution (in 5 year age bands)

nary Heart Disease

ges	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90 - 94	95 - 99	100 - 104	105 - 109	Total
	0	0	0	0	0	0	0	0	1	3	5	12	12	18	18	10	7	10	3	1	0	0	100
le	0	0	0	0	0	0	0	0	0	0	1	2	6	8	9	7	6	8	2	2	1	0	52
otal	0	0	0	0	0	0	0	0	1	3	6	14	18	26	27	17	13	18	5	3	1	0	152

ke/TIA

ges	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90 - 94	95 - 99	100 - 104	105 - 109	Total
	0	0	0	0	0	0	1	0	1	0	0	3	5	8	4	8	3	10	2	0	0	0	45
le	0	0	1	0	0	0	0	1	1	1	0	2	4	5	4	7	10	6	3	0	0	0	45
otal	0	0	1	0	0	0	1	1	2	1	0	5	9	13	8	15	13	16	5	0	0	0	90

pheral Vascular Disease

ges	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90 - 94	95 - 99	100 - 104	105 - 109	Total
	0	0	0	0	0	0	0	0	0	1	1	1	4	3	5	3	1	2	1	0	0	0	22
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otal	0	0	0	0	0	0	0	0	1	1	1	2	9	5	6	10	4	4	2	2	0	0	47

l Fibrillation

rdiovascular Disease Audit

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75 The Broadshires Health Centre

od: 09/04/2008

Double-click table name for graph

Sex Patients Distribution (in 5 year age bands)

l Fibrillation

ges	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90 - 94	95 - 99	100 - 104	105 - 109	Total
	0	0	0	0	0	0	0	1	3	3	3	3	4	3	6	6	5	5	1	0	0	0	43
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otal	0	0	0	0	0	0	1	1	3	3	3	3	6	6	10	9	10	8	3	2	0	0	68

t Failure

ges	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90 - 94	95 - 99	100 - 104	105 - 109	Total
	0	0	0	0	0	0	0	0	0	1	1	3	2	5	7	5	4	10	1	1	0	0	40
le	0	0	0	1	1	0	0	0	1	0	1	2	3	5	4	4	6	10	3	0	1	0	42
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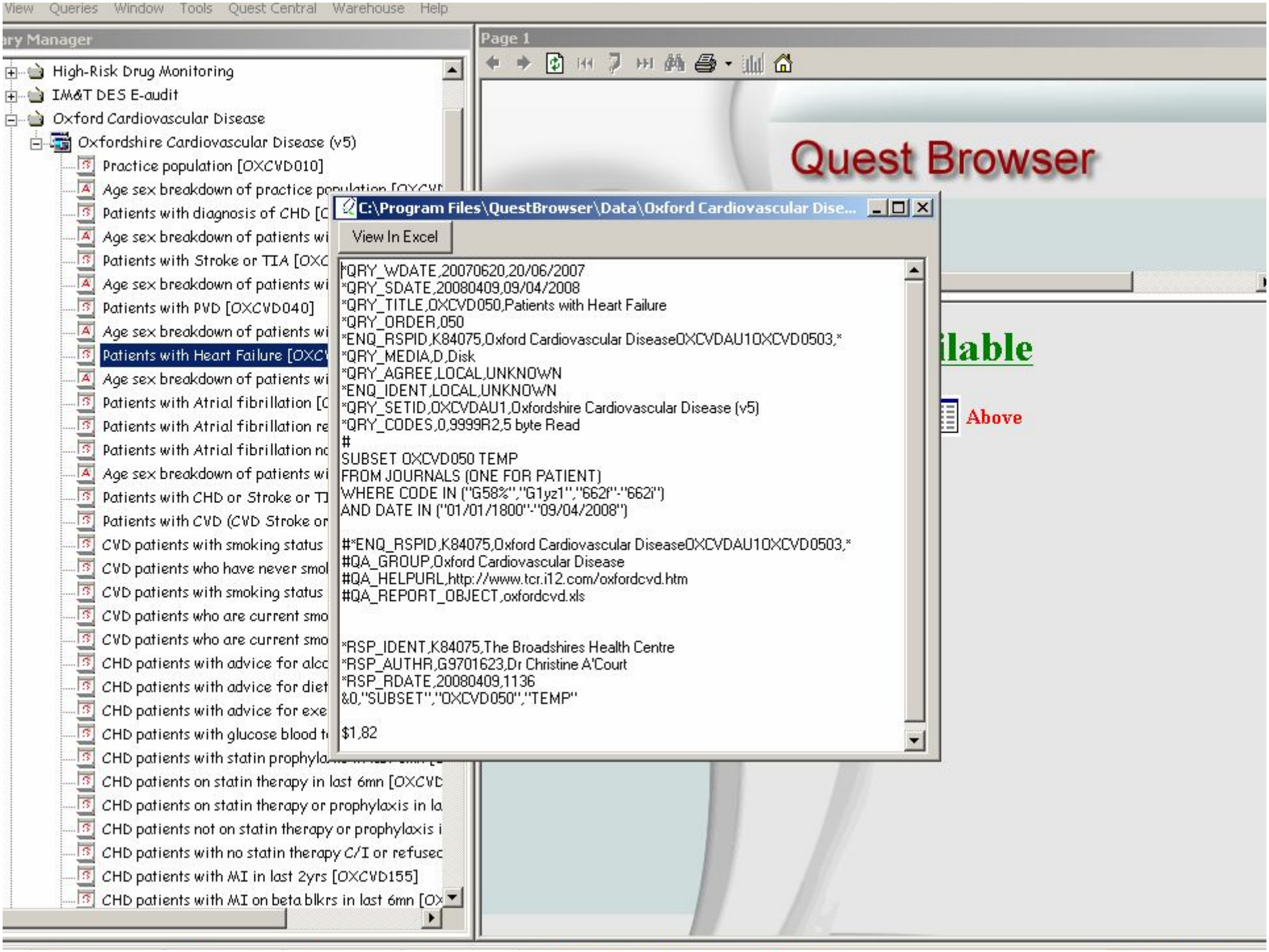
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Oxfordshire Cardiovascular Disease (v5)
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Patients with Stroke or TIA [OXC
Age sex breakdown of patients wi
Patients with PVD [OXCVD040]
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CHD patients with MI in last 2yrs [OXCVD155]
CHD patients with MI on beta blkrs in last 6mn [OX
Page 1
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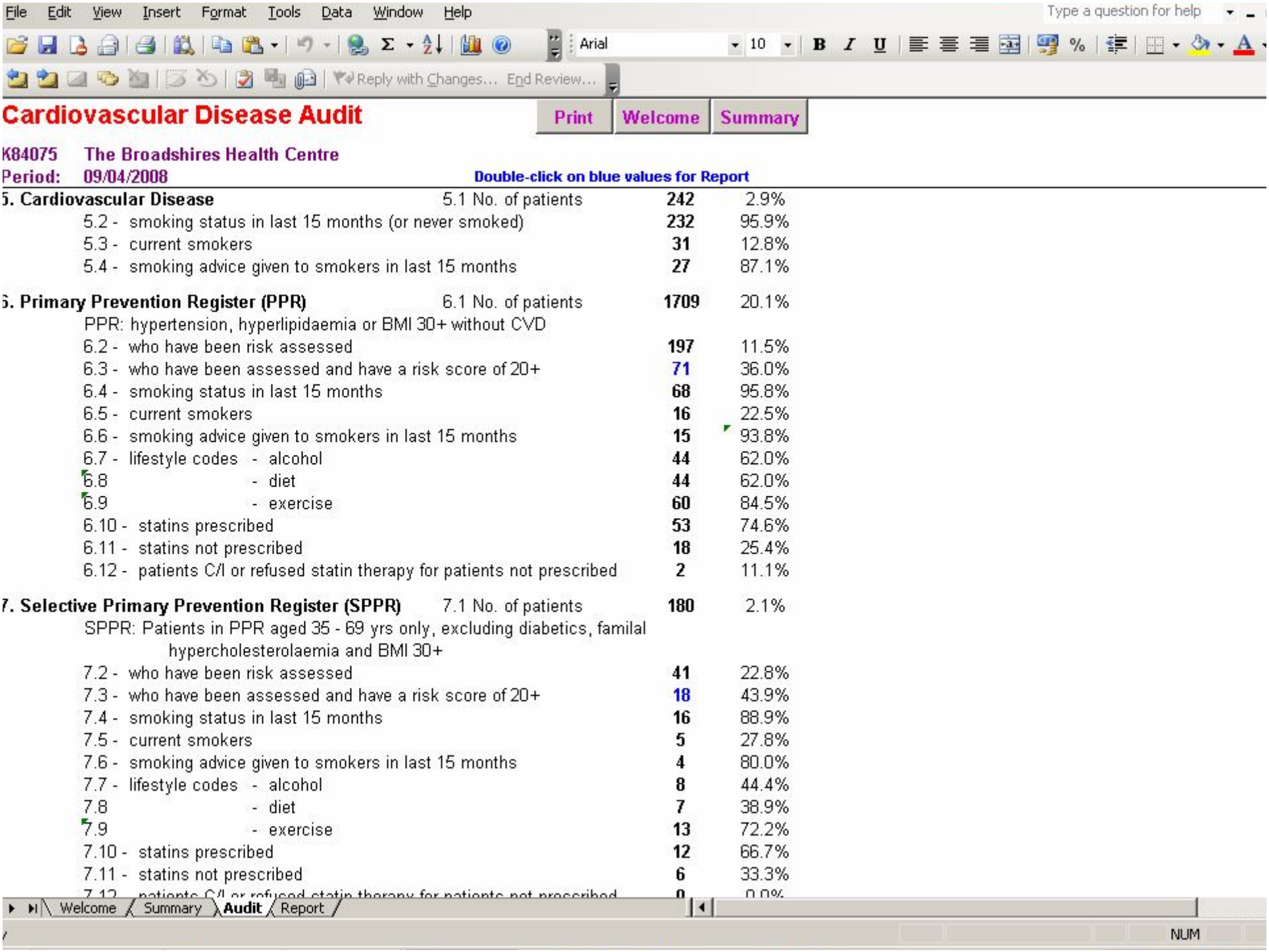
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Cardiovascular Disease Audit
Print
Welcome
Summary
K84075 The Broadshires Health Centre
Period: 09/04/2008
Double-click on blue values for Report
5. Cardiovascular Disease 5.1 No. of patients 242 2.9%
5.2 - smoking status in last 15 months (or never smoked) 232 95.9%
5.3 - current smokers 31 12.8%
5.4 - smoking advice given to smokers in last 15 months 27 87.1%
6. Primary Prevention Register (PPR) 6.1 No. of patients 1709 20.1%
PPR: hypertension, hyperlipidaemia or BMI 30+ without CVD
6.2 - who have been risk assessed 197 11.5%
6.3 - who have been assessed and have a risk score of 20+ 71 36.0%
6.4 - smoking status in last 15 months 68 95.8%
6.5 - current smokers 16 22.5%
6.6 - smoking advice given to smokers in last 15 months 15 93.8%
6.7 - lifestyle codes - alcohol 44 62.0%
6.8 - diet 44 62.0%
6.9 - exercise 60 84.5%
6.10 - statins prescribed 53 74.6%
6.11 - statins not prescribed 18 25.4%
6.12 - patients C/I or refused statin therapy for patients not prescribed 2 11.1%
7. Selective Primary Prevention Register (SPPR) 7.1 No. of patients 180 2.1%
SPPR: Patients in PPR aged 35 - 69 yrs only, excluding diabetics, familal hypercholesterolaemia and BMI 30+
7.2 - who have been risk assessed 41 22.8%
7.3 - who have been assessed and have a risk score of 20+ 18 43.9%
7.4 - smoking status in last 15 months 16 88.9%
7.5 - current smokers 5 27.8%
7.6 - smoking advice given to smokers in last 15 months 4 80.0%
7.7 - lifestyle codes - alcohol 8 44.4%
7.8 - diet 7 38.9%
7.9 - exercise 13 72.2%
7.10 - statins prescribed 12 66.7%
7.11 - statins not prescribed 6 33.3%
7.12 - patients C/I or refused statin therapy for patients not prescribed 0 0.0%
Welcome Summary Audit Report
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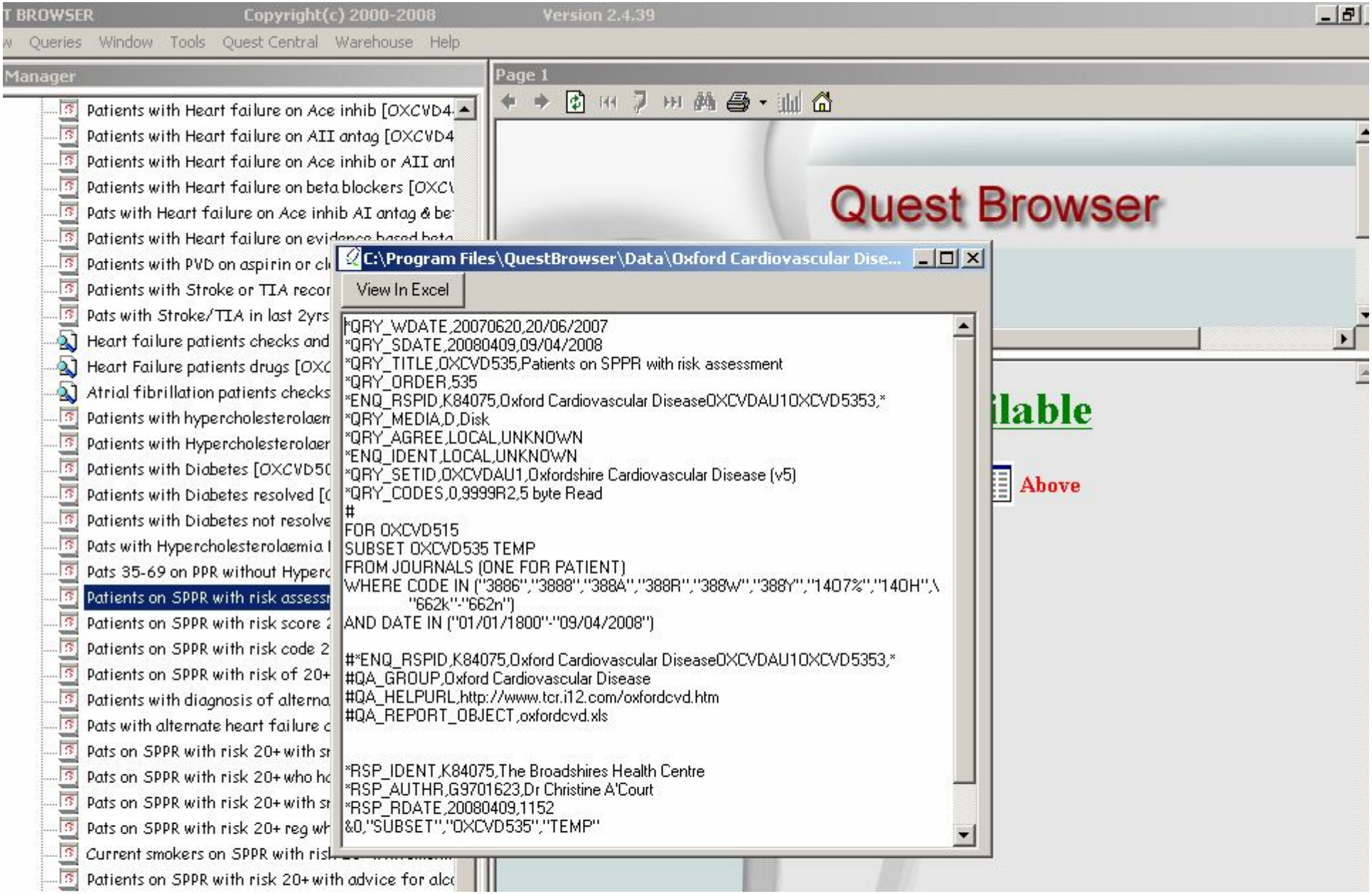
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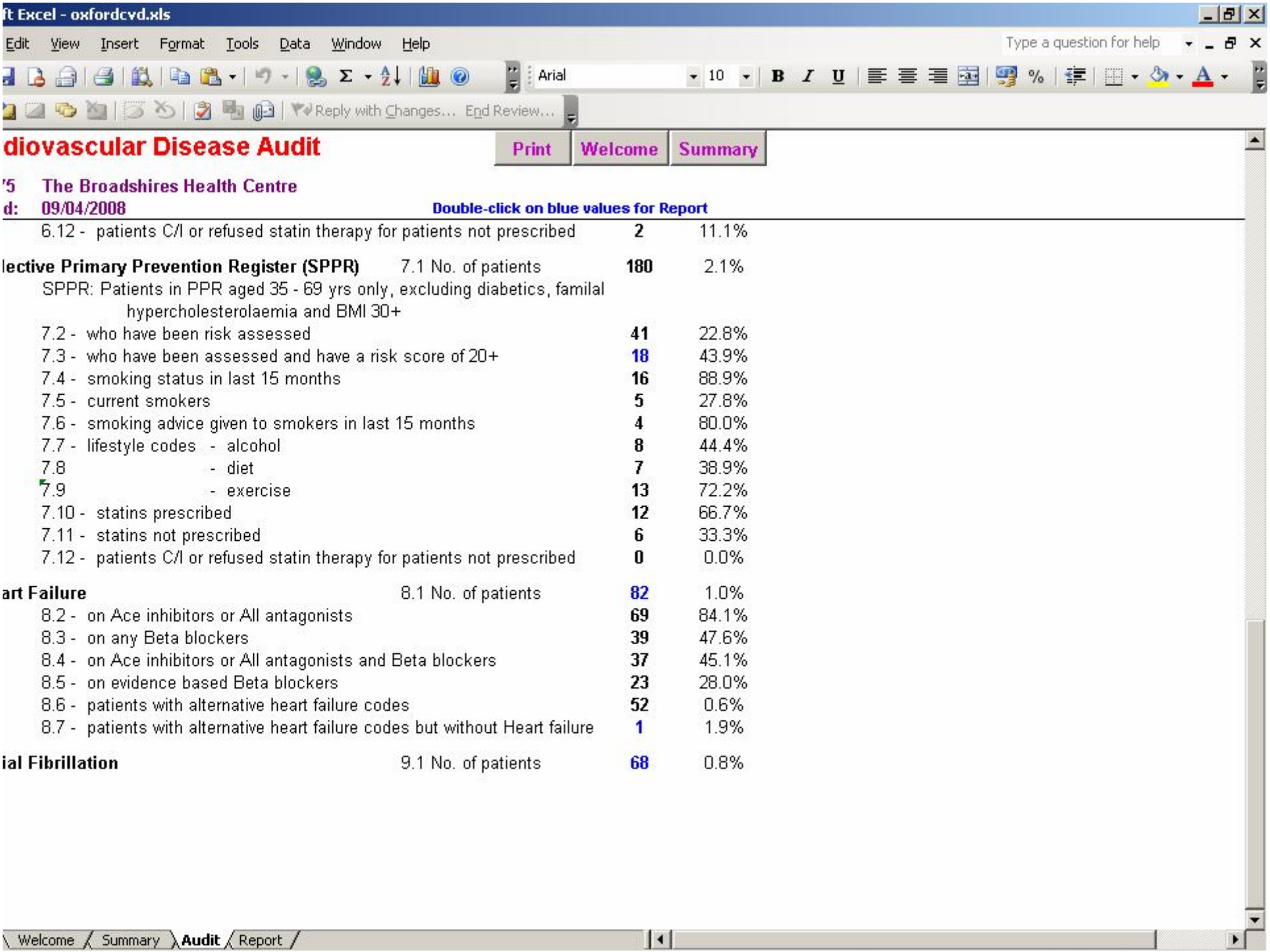
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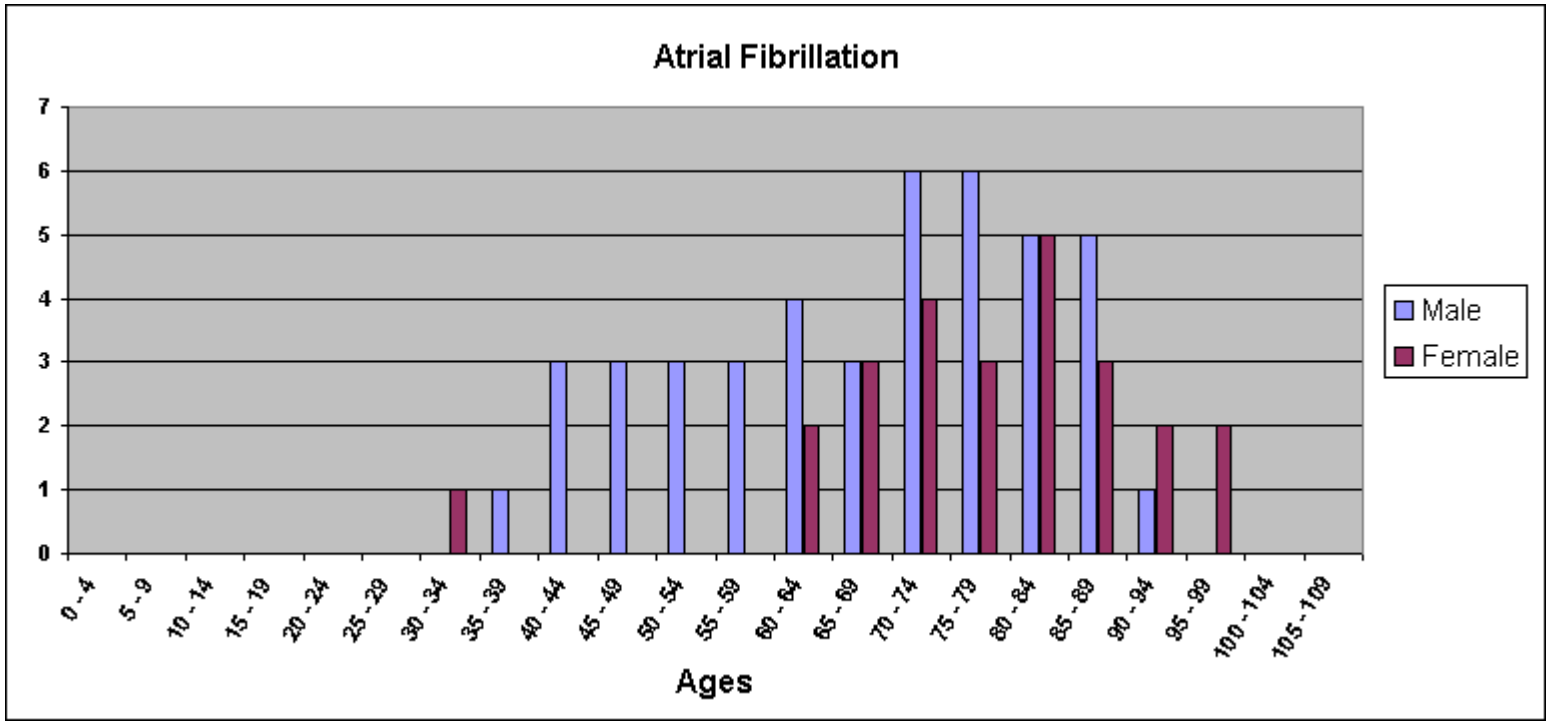
7.9 - exercise 13 72.2%
7.10 - statins prescribed 12 66.7%
7.11 - statins not prescribed 6 33.3%
7.12 - patients C/I or refused statin therapy for patients not prescribed 0 0.0%
art Failure 8.1 No. of patients 82 1.0%
8.2 - on Ace inhibitors or All antagonists 69 84.1%
8.3 - on any Beta blockers 39 47.6%
8.4 - on Ace inhibitors or All antagonists and Beta blockers 37 45.1%
8.5 - on evidence based Beta blockers 23 28.0%
8.6 - patients with alternative heart failure codes 52 0.6%
8.7 - patients with alternative heart failure codes but without Heart failure 1 1.9%
ial Fibrillation 9.1 No. of patients 68 0.8%
Welcome Summary Audit Report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Ages
Male
Female

Other QUEST tools

- GMS Contract v24
  - Searches to enhance all GMS registers
  - Identifies patients with Read Codes suggestive of condition but not on register
  - High ‘hit rate’
- GMS Contract v25
  - Identifies patient with missing QOF points
  - Creates letters, does mail merge

Exception Reporting: Lessons from QOF ‘pre-verification’ visits

Took place Oct 07-Jan 08,

based on 2006-07 QMAS data,

determine release of payments for 07-08

Why monitor and visit?

- PCT has to justify payment of £10-15M
- GPs and teams constantly find areas to debate, demur and deviate!
- need to make sure distribution of payments ‘fair’
- PCT understands that there is still a lot to learn about monitoring QOF, but hope that each year the process will improve and be more consistent
- Oxfordshire has high rate of Exception Reporting

Summary of pre-agreed criteria for visits

- 14 practices visited due to one or more criteria:
  - Outliers for prevalence in several QOF clinical domains
  - Outliers for exception reporting
  - If PCT + Clinical Governance Lead concerns
  - Level of QOF achievement unexpectedly low or high
  - Significant organisational changes during the previous year
  - New contractors
  - Inadequate evidence submitted for one or more indicators in the previous year

Some examples of practice visits

Commentary focussing on exception reporting in asthma and COPD

Practice 1

Indicator	Practice %	PCT average %
Asthma 6 (Review)	14.4	4.5
BP 5 (<150/90)	6.8	5.5

Explanations in Practice 1

- Historically-GPs unimpressed by impact of P/N respiratory reviews, and the need to still see GPs for medication reviews. GPs reviewed using the 3 Symptom questions, PEFR +/- inhaler check
- Monthly list of invitees to asthma clinic, and after 3 invites entered ‘informed dissent’ to facilitate admin
- Not aware that with EMIS, if ER, lose alerts
- Confused about concurrent asthma & COPD. If had additional COPD, ER’d as ‘unsuitable’ for asthma review

Practice 2

Indicator	Practice %	PCT Average
CHD 5 (BP recorded)	6.7	1.1
CHD 6 (BP<150/90)	10.2	4.1
Asthma 6 (Review)	16.1	4.5
COPD 9 (Review)	23.4	6.8

Explanations for Asthma 6 and COPD 9

- Incorrect diagnoses were exception reported - in preference to changing diagnosis
- Housebound were exception reported ‘unsuitable’ with no further justification
- New P/N with respiratory training-persuaded GPs that GP review inadequate and must see her annually
- But many patients not inclined to attend so after 3 invitations - ER ‘informed dissent’
- Challenged me to look at practice in low ER practices!

Practice 3

Indicator	Practice %	PCT average %
CHD 5 (BP recorded)	2.3	1.1
BP 5 (BP < 150/90)	11.3	5.5
Asthma 6 (Review)	10.9	4.5
CS1	906 patients ER'd	

Explanations in Practice 3

- Don’t need the ERs to attain targets
- Well-organised, personal lists
- Records of asthmatics scrutinised-if diagnosis in doubt ‘unsuitable’ *(‘asthma resolved’ preferable? Or change diagnosis to relevant symptom eg wheeze?)*
- HT & Asthma Clinics, letters monthly, (GP signs +/- annotates the third) and if declined are systematically coded as ‘informed dissent’ (Vision-so no loss of alerts). Most got reviewed anyway.
- Letters did not ‘sell’ the clinics.

Clinical Scenario

- 82 year old, T2DM, previous TIA, CKD Stage 3, previous fractured femur, on lisinopril 20mg and hydrochlorothiazide 12.5mg and amlodipine 5mg for 6 months. BP 152/86. Mentions that since amlodipine added has developed some ankle swelling and sometimes feels dizzy on standing, but not too troublesome. Recognises that BP supra-optimal but is not prepared to take any additional blood pressure treatment. You decide to stick with current regimen.
- Do you ER him as ‘informed dissent’ or ‘on max tolerated treatment’ or ‘patient unsuitable’?

‘Maximum tolerated therapy’

- Already has side-effects and GP/patient do not dare increase therapy
- Had side-effects but got rid of them by cutting back on therapy

‘Informed Dissent’

- Patient does not agree with diagnosis, or believe value of treatment
- Patient believes treatment will cause adverse effects eg impotence and diabetes and cannot be persuaded otherwise
- 3 invitations to clinic not taken up, or not attended (beware EMIS)

‘Patient unsuitable’

- unlikely to benefit from intervention

or

- highly likely to suffer from intervention

or

- or more likely to suffer than to benefit

Exception Reporting-when?

- Early in QOF year circulate last year's ER global exception lists
  - Person who knows patient best makes decision
- As soon as see patient with high risk clinical situation
  - Protect terminal patients from inappropriate invitations & interventions ('Pt Unsuitable', *expiring exception*)
  - Protect frail/fallers/intolerant patients as soon as identified ('Pt Unsuitable' or 'max tolerated', both *expiring*)
  - Protects patients with adverse reactions from re-prescription ('ADR' or 'Drug not tolerated' *persisting*)
- Otherwise wait until Feb/March, check lists
  - Advantageous in EMIS practices where exception reporting causes loss of pop-up alerts

Exception Reporting-how much?

- Just enough to get the indicators over the threshold….?
- Or go through entire list of ‘non-achievers’ and ER when appropriate?
  - Ensures you are well clear of threshold and won’t slip
  - Ensures consistency within practice which enables year on year comparisons
    - Handy if change procedure eg make invitation letters more inviting, offer different times (extended hours), change staff, combine P/N review with medication reviews
  - Ensures consistency which enables valid PCT and national comparisons

IM&T DES

IM&T

- National electronic audit
- Assessing readiness to upload records to NHS spine
- First good assessment of quality of computer summaries
- Yes, ‘fixable’. But may be repeated in 3 years
- 4 components-40p+44p+27p+22p per patient
- Learning points circulated to all practices

IM & T DES e-audit
‘Component 2’

In Oxfordshire we concentrated on

- **Drug to disease audits** Prescriptions indicative of a major chronic diagnosis (for example insulin) linked to an appropriate diagnostic code in the summary record.
- **Allergy audit** Rate of recording of drug and other important allergies and adverse reactions

IM & T DES e audit
Component 2 cont'd

In Oxfordshire we reported on (but did not follow up to same degree):

- **Use of top level chapter Read codes**, the idea being to ensure their minimisation.
- **Recording of Diagnoses** Presence of specified significant, common diagnoses and conditions, relevant to the practice demographics.
- **Miscellaneous codes** eg utilisation of Family history codes
- **Audit of referrals, encounter location and summary recording**
- **Female codes in male records and vice versa**
- **Hysterectomy & Cholecystectomy(multiple counts)**

Relevance of IM&Te-audit to QOF

- Exposed possible problem with Depression registers
- Highlighted need for proper recording of drug allergies & adverse reactions (create an alert) versus use of QOF contraindication codes (expiring, and no alert)

Depression Register

- IM&T LES exposed that in minority of practices large numbers pts on fluoxetine/paroxetine and no diagnosis depression
- ? Due to cleaning up of Serious Mental Illness register
- ? Gaming when no PHQ-9 done (eg use of ‘low mood’ or ‘depressed’)
- PHQ-9 is ‘validated’ questionnaire for assessment of severity of depression (but impact on quality of care not validated)

QOF: ‘Depression 2’

- Legitimate reasons for not doing PHQ-9 questionnaire and Exception reporting as ‘patient unsuitable’
  - non English-speaking (not validated in ethnic minorities)
  - Diagnosis and early management by CMHT or in secondary care
  - Acute psychosis, very distracted, panic
- If you just miss some (forget, locums, time etc)- so be it
- Don’t allow QOF to corrupt accuracy of patient’s health record

DSP approach…

- GPs must hold onto public trust, and administer QOF with integrity
- Where requirements seem ‘stupid’ try and get the best out of them
- Use QOF monitoring visits to clarify and share best practice